

111TH CONGRESS
1ST SESSION

H. R. 2939

To provide for a pilot program to improve the quality of oncology care
under Medicare.

IN THE HOUSE OF REPRESENTATIVES

JUNE 18, 2009

Mr. CROWLEY (for himself, Mr. ROGERS of Michigan, Mrs. CAPPS, Mr. RYAN of Wisconsin, Ms. ESHOO, Mr. KIND, Mr. THOMPSON of California, Mr. GORDON of Tennessee, Mr. PASCRELL, Mr. TIBERI, Ms. BERKLEY, Mr. BLUMENAUER, Mr. DAVIS of Kentucky, Mr. MOORE of Kansas, Mr. GENE GREEN of Texas, Mr. ISRAEL, Ms. SCHWARTZ, and Mr. ALTMIRE) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for a pilot program to improve the quality of
oncology care under Medicare.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Oncology Care Quality
5 Improvement Act of 2009”.

1 **SEC. 2. ONCOLOGY CARE QUALITY IMPROVEMENT PRO-**
2 **GRAM.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services (in this section referred to as the “Sec-
5 retary”) shall establish a pilot program (in this section
6 referred to as the “OCQI program”) under title XVIII of
7 the Social Security Act to evaluate the impact of three
8 provider-led approaches described in subsection (b) to im-
9 prove care quality and outcomes for Medicare beneficiaries
10 with cancer while addressing care cost drivers by creating
11 greater efficiencies in the program.

12 (b) APPROACHES DESCRIBED.—The approaches de-
13 scribed in this subsection are the following approaches to
14 the delivery of oncology care:

15 (1) EVIDENCE-BASED GUIDELINE ADHER-
16 ENCE.—Reducing variation in care through adher-
17 ence to evidence-based guidelines that improves qual-
18 ity and reduces error.

19 (2) PATIENT EDUCATION AND CARE COORDINA-
20 TION SERVICES.—Providing patients with—

21 (A) dedicated educational sessions about
22 the likely effects of their cancers and treat-
23 ments and how to manage those prior to initi-
24 ation of treatment, preferably from an oncology
25 nurse; and

1 (B) continuous support throughout their
2 course of care.

3 (3) END-OF-LIFE PLANNING AND COUNSELING
4 SERVICES.—Providing patients with poor prognoses
5 with end-of-life planning and counseling services
6 with their physicians and nurses in order to em-
7 power such patients and their families with the best
8 information available about their options to assist
9 such patients and families in making difficult
10 choices between pursuing potentially ineffective ag-
11 gressive medical treatments or pursuing hospice care
12 or other palliative care to improve quality of life in
13 their final months.

14 (c) DESCRIPTION.—

15 (1) IN GENERAL.—The OCQI program shall be
16 designed in a manner similar to that for the physi-
17 cian group practice demonstration program under
18 section 1866A of the Social Security Act (42 U.S.C.
19 1395cc–1) and shall provide performance payments
20 to participating oncology groups that implement
21 each of the approaches described in subsection (b)
22 equal to one-half of the program savings generated
23 by the participating group. The other half of pro-
24 gram savings shall be retained by the Medicare pro-
25 gram.

1 (2) EXPENDITURE TARGETS.—Under the OCQI
2 program, the Secretary shall establish per capita ex-
3 penditure targets for participating oncology groups,
4 taking into account the risk characteristics of the
5 patients involved. Those groups that meet the per-
6 formance goals established by the Secretary and
7 achieve program savings against the expenditure tar-
8 gets shall receive performance payments described in
9 paragraph (1).

10 (3) LIMITATION ON NUMBER OF PARTICIPATING
11 GROUPS.—The Secretary shall limit the number of
12 groups that may participate in the OCQI program to
13 no more than 75 groups at any time.

14 (4) LIMITATION ON DURATION.—The OCQI
15 program shall be conducted over a 3-year period.

16 (5) LIMITATION ON PATIENT SELECTION.—The
17 Secretary shall prohibit groups participating in the
18 OCQI program from selecting the individual patients
19 to be included in the program.

20 (6) PENALTIES TO PREVENT REDUCTIONS IN
21 SERVICES.—The Secretary may impose penalties on
22 those groups participating in the OCQI program
23 that the Secretary determines have inappropriately
24 reduced cancer therapies, including supportive care
25 therapies (basing their determination on existing evi-

dence based, medically accurate guidelines). Any such penalties shall be in the form of reductions to performance payments payable to the groups under paragraph (1).

(d) ADVISORY COMMITTEE; EVALUATION.—

(1) IN GENERAL.—The Secretary shall appoint an advisory committee composed of representatives of the oncology community, including organizations representing physicians, nurses, and patients, and industry representatives, to collaborate with the Secretary on the creation and implementation of the OCQI program, including the development of appropriate expenditure targets, and to help analyze the data generated by the OCQI program. The advisory committee shall specifically advise the Secretary on the methods for selecting practices in different regions of the United States to participate in the OCQI program.

(2) EVALUATION.—In consultation with the advisory committee, Secretary shall evaluate the OCQI program to—

(A) assess patient outcomes for patients participating in the program as compared to such outcomes to other individuals for the same health conditions;

1 (B) analyze the cost effectiveness of the
2 services for which performance payments are
3 made under the program, including an evalua-
4 tion of the cost savings to the Medicare pro-
5 gram attributable to reductions in physicians'
6 services, emergency room visits, hospital stays,
7 drug costs, advanced imaging costs, and end-of-
8 life care;

9 (C) determine the satisfaction of patients
10 participating in the program; and

11 (D) refine the appropriate level and pro-
12 portion of the specific performance payments
13 among the three performance components of
14 the program.

15 (e) IMPLEMENTATION.—If the Secretary determines
16 that the OCQI program has been successful in improving
17 care quality while lowering the rate of growth of Medicare
18 program expenditures, the Secretary is authorized to in-
19 clude payments for the specific services paid under the
20 OCQI program as performance payments as permanent,
21 covered services under the Medicare program.

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